Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 16, 2017

Ms. Angela Pelletier, Manager
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Pelletier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on August 30, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

SEP 2 5 2017

PRINTED: 09/14/2017
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite follow-up survey to citations issued as a result of surveys on March 8, 2017 & May 25, 2017 was conducted by the Division of Licensing and Protection on August 28-30, 2017. A complaint investigation was also conducted at this time. The following regulatory deficiencies were identified as a result of this survey, which includes 8 deficiencies that remain uncorrected from the previous surveys:	R100	Please see Corrective Plan of Action letter dated 09/25/2017.	
R101 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to assure that no individual was accepted/retained who meets level of care eligibility for nursing home admission or who otherwise has care needs which exceed what the facility is able to provide. Findings include: Per interviews with the Memory Care Director (MCD) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been	R101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emma M. Gonsalves

TITLE: Executive Director

(X6) DATE: 09/25/17

R101 - R9999 POCs accepted 10/12/17 MHiggins RN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING. _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R101	Continued From page 1 involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. At the time of the survey there is no evidence present that either the Licensed Practical Nurse (LPN) or the RN had done any type of admission screening at the time of admission for R #1,#2, #3 and #4. During the survey visit, an additional 2 residents were admitted without a nurse being involved in any pre-screening process. During observations conducted during the survey, a large number of residents are noted to have significant cognitive impairment, which would qualify them as nursing home level of care. In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the Dementia is so severe that the resident is totally dependent for all aspects of care, the resident is refused admission. Additionally in the record reviews, conducted during the survey, it was discovered that Resident # 4 has a Stage 4 pressure ulcer of the right toe. The Licensed Practical Nurse (LPN) on duty on 8/28/17 confirmed that the resident had a wound present on the toe when admitted to the facility. There is no variance request found for Resident #4.	R101	Please see Corrective Plan of Action attached.	
R126 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's	R126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R126	Continued From page 2 personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: *Repeat Citation. Based upon observations, record review, and interviews the facility failed to assure that necessary services were provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. *This is an uncorrected violation* Findings include: Per interviews with the Memory Care Director (MCD) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. During the survey visit, an additional 2 residents were admitted. In interviews with 2 of 3 families it was stated that they were told that there would be nursing care available for all residents as well as a staffing pattern of 1 staff to every 4 residents. During observations conducted during the survey, a large number of residents appear to have significant cognitive impairment, which may qualify them as nursing home level of care. In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the	R126	Please see Corrective Plan of Action attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R126	Continued From page 3 Dementia is so severe that the resident is totally dependent for all aspects of care, the resident is refused admission. In a review of staff schedules there has been a significant decline in the number of nursing staff. Additionally, there is a graduate nurse on night shift duty who, though recently licensed in New York state, is not licensed in the state of Vermont. S/he has been practicing as an RN. Paperwork in the admission packet does state that there is nursing care for residents 24/7.	R126	Please see Corrective Action Plan attached.	
R134 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assure that an assessment was completed for 6 of 14 sampled residents (Residents # 1, 2, 3, 5, 6, & 7) within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency, and assessing the resident's abilities regarding medication management within 24 hours of admission. *This is an uncorrected violation*	R134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R134	Continued From page 4 Findings include: 1). Resident # 1 was admitted on 8/25/17. There was no initial nursing assessment; no Braden scale; no fall risk assessment; no medication self-administration assessment; no RN completion of the medication assessment within 24 hours and the Resident Assessment Information (RAI) form was not completed within 14 days of admission. 2). Resident #2 was admitted on 8/4/17 . There was a facility nursing assessment form completed by the LPN and no other facility forms completed and no RN completion of the medication assessment within 24 hours. The RAI was also not completed within 14 days of admission. 3). Resident #3 was admitted on 8/17/17. The facility assessment forms were completed by the LPN with no counter signature by the RN and no RN completion of the medication assessment on the RAI. 4). Resident #5 was admitted on 8/21/17. Though the facility admission forms were completed by an LPN there is no RN completion of the medication assessment within 24 hours on the RAI. 5). Resident #6 was admitted on 8/11/17. There were no facility nursing assessment forms completed and no RN completion of the medication assessment within 24 hours on the RAI. 6). Resident #7 was admitted 8/24/27. There was an initial nursing assessment completed by the LPN, a Braden scale, a fall risk assessment, and no RN completion of the medication assessment within 24 hours of admission on the RAI.	R134	Please see Corrective Plan of Action attached.	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING. _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R141 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (1)-(5) are all met: (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and (3) The home is able to meet the resident's needs without detracting from services to other residents; and (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully informed of their options and agree to such care	R141	Please see Corrective Plan of Action attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R141	Continued From page 6 in the residential care home. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation he facility failed to assure that residents requiring more than nursing overview or medication management are not retained in a residential care home. *This is an uncorrected violation* Findings include: 1). Resident # 4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. A physician's note dated 8/16/17 described a right second toe ulcer with infection and exposed bone. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17. 2). During observations conducted during the survey, a large number of residents are noted to have significant cognitive impairment, which would qualify them as nursing home level of care (LOC). In an interview on 8/28/17 the MCD stated that during the pre-screening process s/he does not screen for the level of cognitive impairment but that if the Dementia is so severe that the resident is totally dependent for all aspects of care the resident is refused admission. The facility has two residents with an LOC variance and there are no pending variance requests found in the state agency files. During the survey it is noted that for 14 residents in a sample 6 residents did not have the required RN assessments completed either at all or in a timely fashion.	R141	Please see Corrective Plan of Action attached.	
R142 SS=G	V. RESIDENT CARE AND HOME SERVICES	R142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R142	Continued From page 7 5.8 Level of Care and Nursing Services 5.9.b The following services are not permitted in a residential care home except under a variance granted by the licensing agency: intravenous therapy; ventilators or respirators; daily catheter irrigation; feeding tubes; care of stage III or IV decubitus; suctioning; sterile dressings. This REQUIREMENT is not met as evidenced by. Based on observation, record review and staff interviews, the facility failed to assure that a resident with a Stage 4 pressure ulcer was not retained/admitted to the facility. Findings include: 1). Resident # 4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. A physician's note dated 8/16/17 described a right second toe ulcer with infection and exposed bone. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17.	R142	Please see Corrective Plan of Action attached.	
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an assessment of the resident in accordance with section 5.7. Findings include:	R144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R144	Continued From page 8 1). Resident # 1 was admitted on 8/25/17. There was no initial nursing assessment; no Braden scale; no fall risk assessment; no medication self-administration assessment; no RN completion of the medication assessment within 24 hours and the Resident Assessment Information (RAI) form was not completed within 14 days of admission. 2). Resident #2 was admitted on 8/4/17 . There was a facility nursing assessment form completed by the LPN and no other facility forms completed and no RN completion of the medication assessment within 24 hours. The RAI was also not completed within 14 days of admission. 3). Resident #3 was admitted on 8/17/17. The facility assessment forms were completed by the LPN with no counter signature by the RN and no RN completion of the medication assessment on the RAI. 4). Resident #5 was admitted on 8/21/17. Though the facility admission forms were completed by an LPN there is no RN completion of the medication assessment within 24 hours on the RAI. 5). Resident #6 was admitted on 8/11/17. There were no facility nursing assessment forms completed and no RN completion of the medication assessment within 24 hours on the RAI. 6). Resident #7 was admitted 8/24/27. There was an initial nursing assessment completed by the LPN, a Braden scale, a fall risk assessment, and no RN completion of the medication assessment within 24 hours of admission on the RAI.	R144	Please see Corrective Plan of Action attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R144	Continued From page 9 This was confirmed by the unit nurse on 8/28/17 at 2:45 PM.	R144	Please see Corrective Plan of Action attached.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that the RN oversees the development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment and which describes the care and services necessary to assist the resident to maintain independence and well-being for 6 residents (#1, #4, #10, #5, #8 and #9). *This is an uncorrected violation* Findings include: 1). Resident # 1 was admitted to the facility on 8/25/17 and has multiple medical issues requiring nursing oversight. There is no plan of care to address the resident's needs. 2). Resident # 4 was admitted to the facility on 7/22/17 and has multiple medical issues requiring nursing oversight, including a stage 4 pressure ulcer. There is no plan of care to address the	R145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 10 resident's needs. 3). Resident # 10 was admitted to the facility on 7/6/16 and has multiple medical issues requiring nursing oversight. The resident has had multiple falls at the facility and uses a room monitor and a mechanical lift for transfers. There is no mention of these interventions on the resident's care plan. Two care givers were interviewed on 8/28/17 and had no knowledge of the room monitor. 4). Resident # 5 was admitted to the facility on 8/21/17 and has multiple medical issues requiring nursing oversight. There is no plan of care to address the resident's needs. 5). Resident #8 was admitted to the facility on 1/11/17 and has multiple issues regarding nursing oversight. He has recently been placed on Hospice for the second time since admission. The resident fell on 8/4/17 and was transferred to the Emergency Room (ER). S/he was found to have an Intertrochanteric Fracture of the Left Femur which was not surgically repaired. The resident is not moved from the bed at this time for comfort reasons. In a review of the care plan it states: a). Ambulate as tolerated b). Assist resident getting in and out of bed 1 assist c). Transfer with limited assist using a gait belt and walker d). Limited assist of 1 for ambulation and: Though the resident is receiving an anticoagulant daily the care plan states that "5/13/16 anticoagulant tx DC'd" with no update to reflect the new order. There is also no Hospice/ End Of Life care plan in the record. 6). Resident #9 was admitted to the facility on	R145	Please see Corrective Plan of Action attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 11 7/11/17. The record states that s/he has chronic pain and is at times aggressive, uncooperative, and refuses care. There is no care plan for addressing pain issues and no care plan addressing specific interventions for this resident in relation to the aggression, being uncooperative, and refusing care. The resident has also had a number of falls and though there is a falls care plan it does not address specific interventions which take into consideration her impaired cognitive status.	R145	Please see Corrective Plan of Action attached.	
R146 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the RN provides instruction and supervision to all direct care personnel regarding each resident's health care needs for one resident with an infected Stage 4 pressure ulcer (R#4). Findings include: Nursing staff failed to provide adequate notification and instruction to caregivers for Resident # 4 who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working	R146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R146	Continued From page 12 with the resident. The NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. In interviews 3 of 4 direct caregivers, stated that the nurses did not give them adequate information to care for a resident with MRSA including information regarding the contact precautions to use when caring for R#4. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that s/he received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R146	Please see Corrective Plan of Action attached.	
R150 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9 c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that symptoms or signs of illness was recorded at the time of occurrence, along with action taken for Resident #4. Findings include: Nursing staff failed to assure the presence of illness is recorded at time of occurrence, along with action taken for Resident # 4 who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working with the resident. The	R150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R150	Continued From page 13 NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that h/she received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R150	Please see Corrective Plan of Action attached.	
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the resident's record documents any changes in a resident's condition for a resident with a pressure ulcer. Findings include: Nursing staff failed to document changes in Resident #4's condition, who has an infected stage 4 pressure ulcer. Per a telephone call with a Nurse Practitioner (NP) the NP stated that h/she reported the MRSA to facility nursing staff on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that h/she received the report regarding MRSA and failed to adequately inform staff, write a nursing note and provide additional infection control instruction.	R151		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES	R162		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING. _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R162	Continued From page 14 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that staff does not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order. *This is an uncorrected violation* Findings include: 1). Per record review R#9 was receiving Tylenol 1000mg QID (four times a day) despite an MD order which had discontinued the medication. Additionally, in the month of August the resident was switched back and forth between Ferrous Sulfate 325mg and Ferrous Gluconate 324mg due to staff requests for a new order to match the available form of the medication.	R162	Please see Corrective Plan of Action attached.	
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific	R167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R167	Continued From page 15 behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that delegated staff did not administer as-needed (PRN) psychoactive medications without a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor; and documents the time of, reason for and specific results of the medication use for 5 of 6 residents with psychoactive medications who received those medications on an as needed basis. *This is an uncorrected violation* Findings include: Residents #3, 8, 11, 12, 13, 14 all are prescribed PRN psychoactive medications. None of the residents had a written care plan or behavioral plan to be utilized by unlicensed staff. Review of all medical administration records (MARs) showed that the residents had received the medications. This was confirmed by a facility Med Tech on 8/30/17 at 10:40 AM.	R167	Please see Corrective Plan of Action attached.	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES	R173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R173	Continued From page 16 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure that resident medications are stored in locked compartments under proper temperature controls and that only authorized personnel shall have access to the keys. Findings include: Per observation on 8/30/17, refrigerators on both Junction and Town units were not adequately monitored for proper temperatures. Both refrigerators contained temperature sensitive medications. The Junction refrigerator was last checked on 7/11/17 and no temperatures were recorded in August. The Town unit refrigerator was last checked on 3/31/17. Senior nursing staff indicated that they were unsure who was responsible for checking the temperatures. Additionally, there was an unlocked cabinet in the medication room containing multiple drugs, including antipsychotic medications. Staff were unable to locate a key to lock the cabinet. The Director of Nursing confirmed on 8/30/17 at 12:15 PM that non-delegated staff, including caregivers and housekeepers had keys to the medication room.	R173	Please see Corrective Plan of Action attached.	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to assure that a sufficient number of qualified personnel are available at all times to provide necessary care, maintain a safe environment, and assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. Findings include: 1. Per record review staff interviews there is a Graduate Nurse working as an RN on the night shift. In a review of the personnel file there is no evidence of education or licensure as a Registered Nurse found. In an interview the Executive Director confirmed that there is no evidence that this staff member has actually attained licensure and that s/he told him/her that s/he had passed the boards and is now an RN. In a check of the State Board of Nursing the staff member is not listed as an active RN in the State of Vermont. In an interview on the morning of 8/29/17 the nurse stated that s/he attended nursing school in New York (NY) state and found out that s/he had passed the exam for NY licensure on 8/16/17 and informed the facility. S/he stated that the process for obtaining a Vermont license has begun but that it is still in process.	R178	Please see Corrective Plan of Action attached.	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	Continued From page 18 2. In interviews with 3 families, Family #1 stated that "Though I am very happy with the facility there just isn't enough staff especially at night." Family #2 states that in the past few weeks there has been a huge amount of staff turnover. In both nursing and the caregiver staff, many people have left. The work loads are huge and the residents are difficult to care for because of their Dementia. The main concern is that this facility is chronically understaffed. In the last 2 weeks there have been 5-6 new residents admitted and many staff have left. [Person's spouse] went without a shower for 7 days due to staffing issues. There is also a lot of overtime worked by the current staff. It is a concern that there is often one caregiver in the dining room and that person has to go to the kitchen to get the meals. There are residents who have choking concerns and there may not be staff in the room. Also a resident needed to use the bathroom and it took the family member a long time to find a staff member to help that person. In an interview on 8/28/17 the ED confirmed that the facility has lost several staff members in the past few weeks and that they are attempting to hire more nurses and caregivers.	R178	Please see Corrective Plan of Action attached.	
R189 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement	R189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING. _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R189	Continued From page 19	R189	Please see Corrective Plan of Action attached.	

and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to assure that the record for each resident contains: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation; and resident plan of care. Findings include:

1). Per record review Resident #4 was admitted to the facility on 7/22/17 with a pressure ulcer on the right toe. Though a physician's note dated 8/16/17 described a right second toe ulcer, with infection and exposed bone, there is no nursing description of the wound upon admission and as the wound continued. On 8/28/17 at 2:45 PM, the unit nurse confirmed that the wound was a stage 4 pressure ulcer since at least 8/4/17. There is no plan of care to address the resident's needs. Though the survey team was told that the resident has a wound on her toe which has MRSA, there was no information in the record about when the infection was identified as being positive for MRSA. Per a telephone call with a Nurse Practitioner (NP) and confirmed by a lab report, Resident # 4 has MRSA (methicillin resident staphylococcus aureus). MRSA requires staff to take infection control precautions while working with the resident. The NP stated that h/she reported the MRSA to facility nursing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R189	Continued From page 20 on 8/17/17. On 8/29/17 at 2:35 PM, the facility Registered Nurse (RN) confirmed that s/he received the report regarding MRSA and failed to write a nursing note and provide additional infection control instruction in a plan of care.	R189	Please see Corrective Plan of Action attached.	
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: The facility failed to assure that the results of the criminal record and adult abuse registry checks for all staff were available for one staff member. Findings include: Per record review, for one employee whose personnel file was reviewed, there were no adult and child abuse registry forms found in that record. The absence of these forms was confirmed by the Executive Director on the afternoon of 8/28/17.	R190		
R206 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be	R206		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R206	Continued From page 21 made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the licensee and/or designated staff report any case of suspected neglect to the Adult Protective Services and Survey & Certification, the licensing agency, as required. *This is an uncorrected violation* Findings include: An anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident, a resident fell and responding staff could not locate a third staff member who they believed was a RN for help. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency.	R206	Please see Corrective Plan of Action attached.	
R207 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must	R207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING ___ _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R207	Continued From page 22 not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to assure that the licensee and staff report suspected or reported incidents of abuse, neglect or exploitation. The facility may, and should, conduct its own investigation, that does delay reporting of the suspected incident as required. Findings include: An anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident a resident fell and responding staff could not locate a third staff member for help, who they believed was an RN. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency. In addition, when asked to provide the incident investigation, the ED provided a single sheet with one paragraph, which contained an interview with the Alleged Perpetrator (AP) and the ED. This interview consisted of the AP's denial of having fallen asleep. In an interview on 8/28/17 the ED confirmed that there were no witness interviews (other staff and first responders), conclusions or other information conducted and included in the investigation. The ED also confirmed that the personnel file of the AP did not contain any professional qualification information or abuse background checks.	R207	Please see Corrective Plan of Action attached.	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that residents are free from neglect. Findings include: Per review an anonymous complaint was made regarding an incident which occurred on 8/4/17. During this incident a resident fell and responding staff could not locate a third staff member for help. There was a suspicion of neglect due the the belief that the third staff member had been sleeping on duty. The reported incident resulted in first responders and the Executive Director (ED) being called to the facility. There was no report of this incident made to the state agency. On 8/28/17 the ED confirmed that the incident had not been reported to the state agency. In addition, when asked to provide the incident investigation, the ED provided a single sheet with one paragraph, which contained an interview with the Alleged Perpetrator (AP) and the ED. This interview consisted of the AP's denial of having fallen asleep. In an interview on 8/28/17 the ED confirmed that there were no witness interviews (other staff and first responders), conclusions or other information conducted and included in the investigation. The ED also confirmed that the personnel file of the AP did not contain any professional qualification information or abuse	R224	Please see Corrective Plan of Action attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 24 background checks.	R224	Please see Corrective Plan of Action attached.	
R266 SS=G	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the home failed to provide a safe, and sanitary environment. Findings include: 1). Based on record review Resident #8 was placed on Q15Min (every 15 minute) safety checks after a fall with serious injury. Per observations there were no safety checks completed for a period of 45 minutes on 8/28/17 between 9.45 and 10:30 AM and for an hour and 15 minutes on 8/30/17 between 9 and 10:20 am. During the observation periods a surveyor sat in the resident's room. In a review of the flowsheets for the documentation of 15 minute checks the following is discovered: 7a-3p-for the period of 8/15-29 there is one sheet with no date, there are no dated sheets for 8/19 & 8/21, and for the remainder of the sheets there are 110 checks not initialed as completed. 3p-11p for the period of 8/15-28 there were no dated sheets for 8/18, 25, & 28, and for the remainder of the sheets there are 168 checks not initialed as completed.	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 25 11p-7a-for the period of 8/15-28 there are no dated sheets for 8/15. 16, 17, 18, 20, & 26, and for the remaining sheets 26 checks are not initialed as completed. 2). Per record review Resident #4 has a wound with MRSA. In observations there is no evidence of contact precautions or the need for care when with the resident. Per interviews the staff working with the resident were not informed of the MRSA or educated regarding the proper contact precautions to follow while caring for the resident or handling potentially contaminated linen or clothing, potentially putting all other residents at risk. This was confirmed by the unit nurse in an interview on 8/29/17.	R266	Please see Corrective Plan of Action attached.	
R302 SS=B	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced	R302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R302	Continued From page 26 by: Based on record review and staff interviews the facility failed to assure that fire drills are conducted which rotate times of day among morning, afternoon, evening, and night. *This is an uncorrected violation* Findings include: Per review of facility fire drill records, there is no evidence that drills were carried out on the night shift as required. This was confirmed by the facility Executive Director on 8/28/17.	R302	Please see Corrective Plan of Action attached.	
R999 SS=G	MISCELLANEOUS 4.13.b Whenever the authority is vested in the governing board of a firm, partnership, corporation, company, association or joint stock association, there shall be appointed a duly authorized qualified manager, however named, who will be in charge of the daily management and business affairs of the home, who shall be fully authorized and empowered to carry out the provisions of these regulations, and who shall be charged with the responsibility of doing so. The manager of the home shall be present in the home an average of 32 hours per week. The 32 hours shall include time providing services, such as transporting, or attendance at educational seminars. Vacations and sick time shall be taken into account for the 32-hour requirement. In the event of extended absences, an interim manager must be appointed. This REQUIREMENT is not met, as evidenced by: Based on observations, record reviews and interviews the governing board failed to ensure the Manager carries out all the provisions of the	R999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R999	Continued From page 27 regulations. Findings include: 1). The survey visit included a follow up of Plans of Correction for two previous visits with findings. In the 14 citations issued in the previous visits 8 of those citations remain out of compliance as found in this survey visit. 2). The facility failed to report suspected neglect to the state agency as required. There is no report, by the facility, regarding an incident which was reported through an anonymous source. 3). Per record review the facility failed to obtain verification of education and state licensure for a graduate nurse who practiced as an RN, on the night shift, without another nurse present, and who has not obtained RN licensure in the state of Vermont. There is no information in the file regarding where the staff member obtained a nursing degree or that the staff member passed any state board licensing examination. 4). Per record review the facility failed to conduct a thorough investigation after an incident of alleged neglect and continued to allow the staff member to work. 5). Per family interviews the facility has failed, at times, to have sufficient incontinence care supplies and family members have actually gone out to buy additional supplies for their family member and others. 6). Per interviews with the Memory Care Director (MCO) on 8/28/17, since March of 2017 s/he has not had the input of a Nurse for the pre-admission assessments of a number of residents, and in several instances was not aware of an admission until it happened. In an interview on 8/29/17 the	R999	Please see Corrective Plan of Action attached.	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	R-C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R999	Continued From page 28 Registered Nurse (RN), serving as the nurse oversight, confirmed that s/he had not been involved in any admissions in the two weeks s/he has been serving in that capacity. In the month of August, 6 residents were admitted to the facility. At the time of the survey there is nc evidence present that either the Licensed Practical Nurse (LPN) or the RN had done any type of admission screening at the time of admission for R #1,#2, #3 and #4. During the survey visit, an additional 2 residents were admitted without a nurse being involved in any pre-screening process.	R999	Please see Corrective Plan of Action attached.	

at Essex
specializing in
Memory Care
A WoodBine Senior
Living Community

September 25, 2017

Ms. Pamela M. Cota, RN
Licensing Chief
Vermont Agency of Human Services
Department of Disabilities, Agency and Independent Living
Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Cota:

In response to the letter received dated September 14, 2017 regarding the follow-up survey and complaint investigation that was completed by the Division of Licensing and Protection on August 30, 2017, I respectfully submit our Plan of Correction.

In reference to multiple deficiencies that were included in this report pertaining to the admission of Resident #4, it was indicated that this Resident was admitted with a Stage 4 ulcer of the right toe. In all of the documentation and notes that were included in this residents' chart, we were not able to locate the verbiage in the hand-written notes by the VNA Wound nurse, nor from the surgeon who had evaluated this Resident that would have confirmed that this was a Stage 4 pressure ulcer. Be that as it may, we respectfully submit to you, our Corrective Plan of action as if this was the case, to inform the Division of License and Protection how we would address this.

R101SS=E

We acknowledge the findings that not all preadmission assessments were conducted by a nurse.

1. Effective August 30, 2017, all preadmissions assessments/screenings will be completed by the Director of Nurse and Memory Care Director

2. Since this investigation on August 30, 2017, we have a full-time Registered Nurse on staff as our Director of Nursing. Complete 9/4/17

3. The "Resident Physical Assessment Prior to Move-In" policy Prior to move in, has been read and reviewed by the Management Team on September 25, 2017 (Attachment A).
Complete 9/25/17

802 872-1700
6 Freeman Woods
Essex Junction, VT 05452
www.springvillageessex.com

R101SS=E (cont.)

Spring Village at Essex will not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what Spring Village at Essex is able to provide.

4. As of August 30, 2017, all potential residents have a pre-admission assessment, completed by the Community's full time Registered Nurse or LPN designee. There are no other residents in the Community with a stage 3 or 4 pressure area.

5. The Community's Resident Assessment Form will now include documentation relating to orientation with person, place and time. Medical needs, mood and behavioral concerns will continue to be assessed. Any resident who has care needs which exceeds what Spring Village can provide will be refused admission. As of August 30, 2017, any resident assessed with a stage 3 or 4 wound will have a variance completed by the Community RN. The Physician will be immediately notified and wound care interventions will be included on the Resident's Care Plan. Services from a Wound Care Specialist will be obtained as needed. The Community RN and nurse has been in-serviced pertaining to the submission of variance forms to the licensing agency. This was completed on September 24, 2017. (Attachment B)

Complete 9/24/17

6. Resident files that have been identified as new to the Community, or those identified as requiring a variance, will be audited weekly by the Executive Director and the findings will be shared in a weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m.

7. If it is deemed that the documentation is not filled out properly and the procedure has not been adhered to, a written warning will be given and additional training/in-service will be required. A review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page.

R126 SS=E

1. We acknowledge the findings that not all preadmission assessments were conducted by a nurse. Going forward, all preadmissions assessments will be done by an RN or an LPN. Since this investigation on August 30, 2017; we have hired a full-time Registered Nurse on staff as our Director of Nursing. Spring Village at Essex will not accept or retain as a resident, any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what Spring Village at Essex is able to provide. Completed: ~~August 30, 2017~~.

Complet 9/30/17

R126 SS=E (cont.)

2. As of August 30, 2017, all potential residents have had a pre-admission assessment, completed by the Community's full time Registered Nurse/or LPN designee. Complete 9/30/17

3. The Executive Director and the Department Head Management Team has reviewed the approved (May 11, 2017) Specialty Care Unit Description of Services and Programs Submission (section "S" The Criteria for Admission, Continued Stay and Discharge"). The Resident Physical Assessment Policy and Procedure has also been reviewed by the Executive Director and the Department Head Management Team. Date Completed: September 25, 2017 (Attachment C). complete 9/25/17

4. In order to insure adequate staffing, Spring Village at Essex has signed an agreement with a third-party agency to provide nursing and care provider coverage until qualified, permanent employees are hired. Date Completed: September 25,2017. In addition, Spring Village at Essex will schedule a Family Meeting to inform and educate all resident's responsible parties relative to staffing initiatives and to provide a forum for questions/and answers. Family meeting is scheduled for Thursday, October 12, 2017 at 6:00 p.m. Complete 10/12/17

Complete 9/25/17

5. The individual referenced as the graduate nurse on the night shift was terminated on September 15, 2017. (Attachment D) Complete 9/15/17

6. A New Hire Check list has been revised and updated to provide hiring guidelines and the information necessary for the hiring process. All staff involved in hiring have been educated on this process. (Attachment E). Date Completed: September 25, 2017. complete 9/25/17

7. Effective September 26, 2017, all new employee files will be audited by the Executive Director and will share results in the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m. If it is deemed that the documentation is not filled out properly and the procedure has not been adhered to, a written warning will be given and additional training/in-service will be required.

R134 SS=E

1. We acknowledge that the original nursing assessments for Resident number 1, 2, 3, 5, 6 and 7 as referenced in the findings, were not completed in the 14-day requirement per the Vermont Rules and Regulations.

2. Assessments for Residents 2,3,5,6,&7 were completed on September 23 and September 24, 2017. (Attachment F). *Please note that Resident #2 had passed away on September 7, 2017 and that assessment is not included in this attachment.* Complete 9/23 + 9/24/17

R134 SS=E (cont.)

3. All nurses have reviewed the Resident Assessment and Clinical Care Plan Policy and understand the time frames for completion. Date Completed: September 24, 2017. (Attachment G)
Complete 9/24/17
4. The New Resident/Annual Assessment charting spreadsheet has been updated as of 09/22/2017. (Attachment H) Complete 9/22/17
5. The Executive Director will perform weekly chart audits to insure that all assessments are completed within the regulatory time frames. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

R141 S=E

We acknowledge the findings with reference to Resident #4 who was admitted on 07/22/2017 with a pressure ulcer on the right toe.

Prior to move in, Resident Physical Assessment has been read and reviewed by the Management Team

1. Spring Village at Essex will not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what Spring Village at Essex is able to provide.

2. As of August 30, 2017, all potential residents have a pre-admission assessment, completed by the Community's full time Registered Nurse or LPN designee. There are no other residents in the Community with a stage 3 or 4 pressure area.

3. The Community's Resident Assessment Form will now include documentation relating to orientation to person, place and time. Medical needs, mood and behavioral concerns will continue to be assessed. Any resident who has care needs which exceeds what Spring Village can provide will be refused admission. As of August 30, 2017, any resident assessed with a stage 3 or 4 wound will have a variance completed by the Community RN. The Physician will be immediately notified and wound care interventions will be included on the Resident's Care Plan. Services from a Wound Care Specialist will be obtained as needed. The Community RN and nurse has been in-serviced pertaining to the submission of variance forms to the licensing agency. Completed September 24, 2017 (Attachment A)
Complete 9/24/17

R141 S=E (cont.)

With reference to the "significant cognitive impairment", the Resident Assessment form includes cognitive patterns, section C.1.(Attachment I)

1. The entire management team has read and acknowledged the approved (May 11, 2017) Specialty Care Unit Description of Services and Programs Submission (section "S" - The Criteria for Admission, Continued Stay and Discharge"). Completed September 25, 2017 (Attachment K). Complete 9/25/17
2. All assessments have been completed on September 23 and September 24, 2017. All nurses have reviewed the Resident Assessment and Care Plan Policy. Completed September 24, 2017. Complete 9/24/17
3. Going forward, the New Resident/Annual Assessment charting spreadsheet has been updated as of September 22, 2017. (Attachment H) Complete 9/22/17
4. The Executive Director will perform weekly chart audits to insure that all assessments are completed within the regulatory time frames. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

R142 SS=G

We acknowledge the findings with reference to Resident #4 who was admitted on 07/22/2017 with a pressure ulcer on the right toe.

Prior to move in, Resident Physical Assessment has been read and reviewed by the Management Team

1. Spring Village at Essex will not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what Spring Village at Essex is able to provide.
2. As of ~~August~~ Sept 30, 2017, all potential residents have a pre-admission assessment, completed by the Community's full time Registered Nurse or LPN designee. There are no other residents in the Community with a stage 3 or 4 pressure area. Complete 9/20/17
3. The Community's Resident Assessment Form will now include documentation relating to orientation to person, place and time. Medical needs, mood and behavioral concerns will continue to be assessed. Any resident who has care needs which exceeds what Spring Village can provide will be refused admission. As of August 30, 2017, any resident assessed with a stage 3 or 4 wound will have a variance completed by the Community RN. The Physician will be immediately notified and wound care interventions will be included on the Resident's Care Plan. Services from a Wound Care Specialist will be obtained as needed. The Community RN and nurse has been in-serviced pertaining to the submission of variance forms to the licensing agency. Completed September 25, 2017. (Attachment A)
Complete 9/25/17

R142 SS=G (cont.)

4. The Executive Director will perform weekly chart audits to insure that all assessments are completed within the regulatory time frames. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

5. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R144 SS=E

We acknowledge that the original nursing assessments for Resident number 1, 2, 3, 5, 6 and 7 as referenced in the findings, were not completed in the 14-day requirement per the Vermont Rules and Regulations.

1. All resident assessments referenced above, have been completed on September 23 and September 24, 2017. All nurses have reviewed the Resident Assessment and Care Plan Policy. Completed on September 24, 2017. *Please note that Resident #2 had passed away on September 7, 2017 and that assessment is not included in this attachment.* Complete 9/24/17

2. The New Resident/Annual Assessment charting spreadsheet has been updated as of September 22, 2017. (Attachment H) Complete 9/22/17

3. The Executive Director will perform weekly chart audits to insure that all assessments are completed within the regulatory time frames. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

4. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R145 SS=E

We acknowledge that the original Care Plan for Resident number 1, 4, 10, 5, 8 and 9 as referenced in the findings, were not completed and/or updated. (Attachment L)

1. All have been completed/updated on September 23 and September 24, 2017. All nurses have reviewed the Care Plan Policy on September 24, 2017 and have signed acknowledging that review. (Attachment M). complete 9/24/17

2. The Executive Director will perform weekly chart audits to insure that all assessments are completed within the regulatory time frames. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

3. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R146 SS=E

We acknowledge that adequate notification and instructions were not given to caregivers for Resident #4.

1. A sign will be placed on Residents door, redirecting visitors and staff to see the nurse before entering the resident's room. (Attachment O)

2. All staff providing direct care will complete an in-service focusing on the (diagnosis needing infection control instructions. A signature from the staff stating that they have received and understand the information given to them will be provided. This in-service will be provided in a mandatory Community Meeting that will be held on Wednesday, September 27, 2017. complete 9/27/17

3. An Infection Control book has been created with a checklist (Attachment P). The nurse receiving confirmation of what that outbreak may be, will be required to follow the steps in the checklist, and will be required to provide a statement indicating what was done, when it was done, who was notified and what that outcome was. The Director of Nursing will be required to sign off acknowledging the steps. Complete 9/27/17

4. The Executive Director will audit the Infection Control Book insure that the process and procedure from start to end have been properly executed. (Attachment F). Results of these audits will be presented in the weekly Quality Assurance Meeting that is scheduled for Thursday's at 1:00 p.m. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

R146 SS=E (cont.)

5. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R150 SS=D / R151 SS=D

1. We acknowledge the findings with reference to Resident #4 who was admitted on 07/22/2017 with a pressure ulcer on the right toe.

2. Prior to move in, Resident Physical Assessment has been read and reviewed by the Management Team. Completed September 25, 2017. Complete 9/25/17

3. Spring Village at Essex will not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what Spring Village at Essex is able to provide.

1. As of August 30, 2017, all potential residents have a pre-admission assessment/screening, completed by the Community's full time Director of Nursing and Memory Care Coordinator. Registered Nurse or LPN designee. There are no other residents in the Community with a stage 3 or 4 pressure area. Complete 9/30/17

2. The Community's Resident Assessment Form will now include documentation relating to orientation to person, place and time. Medical needs, mood and behavioral concerns will continue to be assessed. Any resident who has care needs which exceeds what Spring Village can provide will be refused admission. As of August 30, 2017, any resident assessed with a stage 3 or 4 wound will have a variance completed by the Community RN. The Physician will be immediately notified and wound care interventions will be included on the Resident's Care Plan. Services from a Wound Care Specialist will be obtained as needed. The Community RN and nurse has been in-serviced pertaining to the submission of variance forms to the licensing agency. Completed September 24, 2017. (Attachment A)

Complete 9/24/17

R162 SS=E / R167 SS=E

We acknowledge that additional training and education is needed for any staff that is responsible for medication management.

1. When a medication has been discontinued, the medication will be removed from the medication cart by the Community's RN/LPN only, and destroyed according to our policy and procedures relating to the destruction of medication. An Audit of the discontinued medication in the medication cart was performed by the Director of Nursing and completed on September 24, 2017.

complete 9/24/17

R162 SS=E / R167 SS=E (cont.)

2. The Director of Nursing has scheduled medication training over a 3-day period beginning October 2, 3, 4, 2017, respectively. All staff that are involved with the medication management, will be retrained on the dates above. The training will include discontinued orders, process for ordering medications, checking medications when they arrive, and transcribing orders as well as documenting med errors as they occur. Complete 10/4

3. Medication administration, documentation, error report, records and narcotic administration policies will all be reviewed during the October medication training; a signature will be required to acknowledge that they understand the process and procedures.

4. An audit will be performed by the Director of Nursing on a weekly basis, confirming that the process is being adhered to.

5. Results of these audits will be presented in the weekly Quality Assurance Meeting that is scheduled for Thursday's at 1:00 p.m. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

6. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

We acknowledge that Behavior and Care Plans for Residents (3, 8, 11, 12, 13, 14) identified as taking (PRN) psychoactive medications were not complete.

1. All have been completed on September 23 and September 24, 2017. All staff administering medication will be required to attend the three-day October training. This will also include Psychoactive PRN Use Policy as well as education on how to properly fill out the Psychoactive Medication Monthly Flow Record (Attachment L). Completed 9/24/17

2. The Director of Nursing will do weekly audits insuring that all care plans and Psychoactive Medication documentation is being completed properly. Any issues identified will be addressed with the staff person involved. Outcomes of audits will be reviewed at the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m.

R173 SS=E

We acknowledge that an in-service is needed and will be completed during the October 2nd, 3rd and 4th training surrounding this finding. Complete 10/4/17

1. A 24-hour temperature log has been placed in the Nurse/Med-tech wellness center on each refrigerator and it is the responsibility of the Night Nurse/Med-tech to record and sign off on the log before the end of their shift.

2. The Memory Care Director will be providing random audits throughout the week to insure they are being completed and will keep the filled audits in his/her office for?

3. We acknowledge that at the time of the survey, keys to the cabinet for the locked medications within the Nurse/Med-Tech area were not available. The keys for this locked cabinet have since been found and going forward, those keys will be supplied to the Nurse/Med-Tech, the Director of Nursing will also have a back-up key. A third key will be kept in a secured lock box in the Maintenance Director's office. Complete 9/30/17

4. When it was brought to our attention that the locks to the Nurse/Med-Tech Wellness Centers could be accessed by the care-providing staff (as the lock cores are the same), new locking cores for those designated rooms have been completed on 09/24/2017. Keys for the Nurses/Med-Techs were provided; the Director of Nursing will have a back-up key. A third key will be kept in a secured lock box in the Maintenance Director's office. Complete 9/24/17

5. An audit of the medication in the Nurse/Med-tech rooms, was completed on September 24, 2017 by the Director of Nursing to insure that all medications were accounted for. The findings confirmed Complete 9/24/17

6. The Director of Nursing will do weekly audits insuring that all care plans and Psychoactive Medication documentation is being completed properly. Any issues identified will be addressed with the staff person involved. Outcomes of audits will be reviewed at the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m.

R178 SS=E

In reference to "...the facility has failed to assure that a sufficient number of qualified personnel are available at all times to provide necessary care...", we have signed an agreement with a third-party agency to provide nursing and care provider coverage until we are able to hire permanent employees. The individual referenced as the graduate nurse on the night shift was terminated on September 15, 2017.

1. Effective September 24, 2017, a New Hire Check list has been revised and updated to give clear hiring guidelines and the information necessary with the hiring process. All Department Heads with hiring responsibilities have been given clear instructions on the proper documentation required before an offer of employment is extended. This was completed on September 24 2017.

Complete 9/24/17

R178 SS=E (cont.)

2. As of September 24, 2017, all employee files have been fully audited by the Executive Director to insure all documentation required is in place. Attach copy of your audit outcomes Complete 9/24/17

3. Effective September 25, 2017, the Executive Director will perform weekly audits of all new employee files to insure that documentation, licensing, background checks, etc., are completed with original signatures. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m.

With reference to the findings surrounding the dining services, a new process has been developed; all staff is required to be in-serviced on an ongoing basis, as well as in a mandatory Community Meeting that will be held on Wednesday, September 27, 2017. Complete 9/27/17

1. One care provider, nurse or director will remain in the dining room during meal service at all times, while the other care providers assist with meals or other resident needs.

2. It will be the responsibility of each Director to do rounds during mealtimes to insure that the new process is being adhered to.

3. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

We acknowledge the findings under this section in reference to lack of documentation surrounding the identified Resident, #4.

1. The Director of Nurse has a scheduled medication training over a 3-day period beginning October 2, 3rd and 4, 2017. All staff that are involved with the medication management, will be retrained on the dates above. The training will include D/C orders, process for ordering medications, checking medications when they arrive, and transcribing orders as well as documenting med errors as they occur. Complete 10/4/17

2. Medication administration, documentation, error report, records and narcotic administration policies will all be reviewed during the October medication training and each staff member associated with this training will be required to sign off indicating that they understand these processes and procedures. complete 10/4/17

R178 SS=E (cont.)

We acknowledge that adequate notification and instructions were not given to the Management and staff for Resident #4 who had tested positive for MRSA.

1. A sign will be placed on Residents door, redirecting visitors to see the nurse before entering the resident's room.

2. All staff providing direct care will complete an in-service focusing on the diagnosis needing infection control instructions. A signature from the staff stating that they have received and understand the information given to them will be provided. This in-service will be provided in a mandatory Community Meeting that will be held on Wednesday, September 27, 2017. Complete 9/27/17

3. An Infection Control book has been created with a checklist. The nurse receiving confirmation of what that outbreak may be, will be required to follow the steps in the checklist, and will be required to provide a statement indicating what was done, when it was done, who was notified and what that outcome was. The Director of Nursing will be required to sign off acknowledging the steps. Complete 9/25/17

4. The Executive Director will audit the Infection Control Book insure that the process and procedure from start to end have been properly executed. (Attachment F). Results of these audits will be presented in the weekly Quality Assurance Meeting that is scheduled for Thursday's at 1:00 p.m. Any issues identified will be addressed with the staff person involved for immediate correction. Audits will be reviewed at the weekly Quality Assurance meeting scheduled for Thursday's at 1:00 p.m. Complete

5. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes to the procedures. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R190 SS = D

We acknowledge the findings under this section regarding the results of the criminal record and adult abuse registry checks for all Staff to be included in their personnel files.

1. A New Hire Check list has been revised and updated to give clear hiring guidelines and the information necessary within the hiring process. Any staff with hiring responsibilities have been in-serviced on the proper documentation required ***before*** an offer of employment is extended.

2. As of September 23, 2017, all employee files have been fully audited by the Executive Director to insure all documentation required is in place. An audit will be performed on each new employee file by the Executive Director. The Executive Director will keep a record of this audit. Any issues identified will be corrected immediately. Outcomes of Audits will be reviewed at the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m. Complete 9/23/17

R206 SS=G / R207 SS=G / R224 SS=G

We acknowledge that there was a failure to support the suspected neglect to APS within the 48-hour regulation in addition to a lack of detailed documentation surrounding the internal investigation.

1. A report has been submitted to APS as of 09/25/2017 regarding this incident. complete 9/25/17

2. The Executive Director and Management Team have reviewed the policy and procedure entitled "Allegations of Abuse Reporting Requirements". Completed on September 24, 2017. A mandatory Community Meeting will be held on Wednesday, September 27, 2017, where the reporting requirements will be reviewed with all staff members. May want to include a copy of in-service and participant signatures complete 9/27/17

3. The "Allegations of Abuse Reporting Requirements" are a part of the New Hire Orientation, a handout will be provided to all new employees to read. The Executive Director will review with each new employee and they will sign acknowledging that they understand the process and requirements.

4. At the interview with the licensing surveyor on August 28th, with the Executive Director, the ED failed to produce the witness statement that was signed by one of the care providers on that night to the licensing surveyor. (Attachment G).

5. An in-service was provided to the staff on August 15, 2017 where the Executive Director had presented the policy and procedure in reporting alleged abuse, neglect, etc. to Adult Protective Services. The staff was directed in how to fill the new forms that are readily available in and throughout the community. Those in attendance were required to sign in at the beginning of the one-hour in-service session. (Attachment T). This will be reviewed once again during the mandatory Community meeting to be held on Wednesday, September 27th. The meeting will be documented to include all hand-out materials. complete 9/27/17

6. An email was sent to Walter Decker, investigator for APS on September 24, 2017 inviting him to provide additional training as an in-service for our staff. complete 9/24/17

3. Incident Reports will be audited by the Executive Director and Management Team and will be reviewed in the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m. Any issues identified will be corrected immediately.

R266 SS=G

We acknowledge the findings in this section in reference to the updated care plans for the Resident identified as #8.

1. The care plan for this identified Resident has been updated to reflect the current Residents' needs. Completed on September 24, 2017.

complete 9/24/17

R266 SS=G (cont.)

2. The Memory Care Director will review the 24-hour log on a daily basis insuring that it is being properly documented. This will be discussed and reviewed at the mandatory Community Meeting which will be held on Wednesday, September 27, 2017. The reporting requirements will be reviewed with all staff members and signed off acknowledging their understanding of the process and procedure.

complete 9/27/17

We acknowledge that adequate notification and instructions were not given to the Management and staff for Resident #4 who had tested positive for MRSA.

1. A sign will be placed on Residents door, redirecting visitors to see the nurse before entering the resident's room.

2. All staff providing direct care will complete an in-service focusing on the diagnosis needing infection control instructions. A signature from the staff stating that they have received and understand the information given to them will be provided. This in-service will be provided in a mandatory Community Meeting that will be held on Wednesday, September 27, 2017. Complete 9/27/17

3. An Infection Control book has been created with a checklist. The nurse receiving confirmation of what that outbreak may be, will be required to follow the steps in the checklist, and will be required to provide a statement indicating what was done, when it was done, who was notified and what that outcome was. The Director of Nursing will be required to sign off acknowledging the steps.

Complete 9/25/17

4. The Executive Director will audit the Infection Control Book insure that the process and procedure from start to end have been properly executed. (Attachment F). Results of these audits will be presented in the weekly Quality Assurance Meeting that is scheduled for Thursday's at 1:00 p.m.

5. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance. Updates to policies and procedures will be made to reflect any changes. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R302 SS=B

We recognize and acknowledge the findings in reference to the Disaster and Emergency Preparedness Regulation.

1. The requirement was reviewed with the Maintenance Director on September 22, 2017. A fire drill was conducted on 09/06/2017 at 6:35 a.m. and was documented accordingly. (Attachment S)

Complete 9/22/17

R302 SS=B (cont.)

2. A schedule has been created for the remaining 2017 calendar year, where the drills are scheduled for each shift at various times. This schedule will only be made available to the Maintenance Director and the Executive Director. This schedule will be adhered and properly documented in a timely manner. Complete 9/22/17

3. The Executive Director will audit the Fire Drill Log on a monthly basis post fire drill and the results will be discussed in the weekly Quality Assurance Meeting scheduled for Thursday's at 1:00 p.m. If it is deemed that the process is not working, a thorough review of the process will be discussed at the weekly Quality Assurance Meeting to discuss other solutions to ensure compliance and to identify where additional training is required.

4. Updates to policies and procedures will be made to reflect any changes. Each update will include "Revised" with the date of revision at the bottom of the page. Employees will be required to sign off on the "Revised" process acknowledging that the changes(s) have been communicated to them.

R999 SS = G

1. As the Executive Director for Spring Village at Essex, I acknowledge and take full responsibility for the findings within this section and within this report.

2. I have re-read the Residential Care Home Licensing Regulations. The Executive Director and the entire Management Team will review the Regulations together at a weekly meeting until all Regulations have been read, reviewed and discussed. Each Director and Management will acknowledge their understanding of each section by initial. Our schedule is as follows:

• Section 1- 3	September 28th	complete 10/5/17
• Section 4	October 5th	complete 10/5/17
• Section 5	October 12th	Complete 10/12/17
• Section 6 – 11	October 19th	

3. During this time of corrective action, additional support and training is being provided by the Director of Operations of the Community's management company and will be providing said additional training in-house one on one with the Executive Director.

Executive Director terminated 9/27/17

I would like to communicate on behalf of myself and the entire management team at Spring Village at Essex, not only to the Division of Licensing and Protection and Adult Protective Services, but also to the families and Residents that we serve, that I acknowledge the seriousness of this survey, including but not limited to the uncorrected deficiencies that had been identified in prior survey's, as well as the importance of the charge that I have been entrusted with for the Community as the Executive Director.

Our business with serving our Residents and supporting their families, is one based on engendering trust one with another, not in just words but also in action. It is our highest priority and our focus to rebuild that trust between the Residents, their families and with the State of Vermont; that through our actions in correcting these deficiencies and putting a Quality Assurance Plan in to place that we prove to those we serve, how we are all fully committed, personally and professionally.

Should you have any questions or need additional information, please feel free to contact me at (802) 872-1700.

Thank you.

Sincerely,

Emma M. Gonsalves
Executive Director

Attachments(s)

WOODBINE
Senior Living

OPERATOR'S PLAN IN PLACE AND SUPPORT TEAM'S RESPONSIBILITIES

WoodBine Senior Living, the Management entity for Spring Village at Essex, has the responsibility for overseeing the Quality Assurance process at Spring Village at Essex. Angela Pelletier, Woodbine Senior Living Director of Operations, has direct oversight for all functions of the Quality Assurance Committee and will report all outcomes directly to Gloria Brock-Gaylor, Owner and Managing Partner at Woodbine Senior Living.

The Quality Assurance Committee, which includes the community's attending physicians, vendors (if applicable) PT, OT, ST, pharmacy, all department heads and the Executive Director are ultimately responsible for insuring community compliance with federal, state and local regulations and for the continual improvement in in the quality and provision of care, hiring process and customer service/satisfaction. Specific areas for review include but would not be limited to: Incident/Accident Reporting Process, Complaint Procedures, Team Member Training, Licensing Violations and Plans of Correction.

The Quality Assurance Meeting at Spring Village at Essex will be held at least monthly in the Community. The Director of Operations will be in attendance at each scheduled Quality Assurance Meeting and will insure, in conjunction with the community Executive Director, that adequate resources are available to conduct all Quality Assurance efforts.

Most importantly, in collaboration with the Community Executive Director, the Director of Operations will insure that all practices are implemented and monitored as established by the Quality Assurance Committee. Corrective actions will be imposed by the Community Executive Director for areas of team member non-compliance. Depending on the circumstance, corrective actions may include: re-education with return demonstration, 1:1 monitoring of team members to insure compliance and disciplinary action up to and including termination.

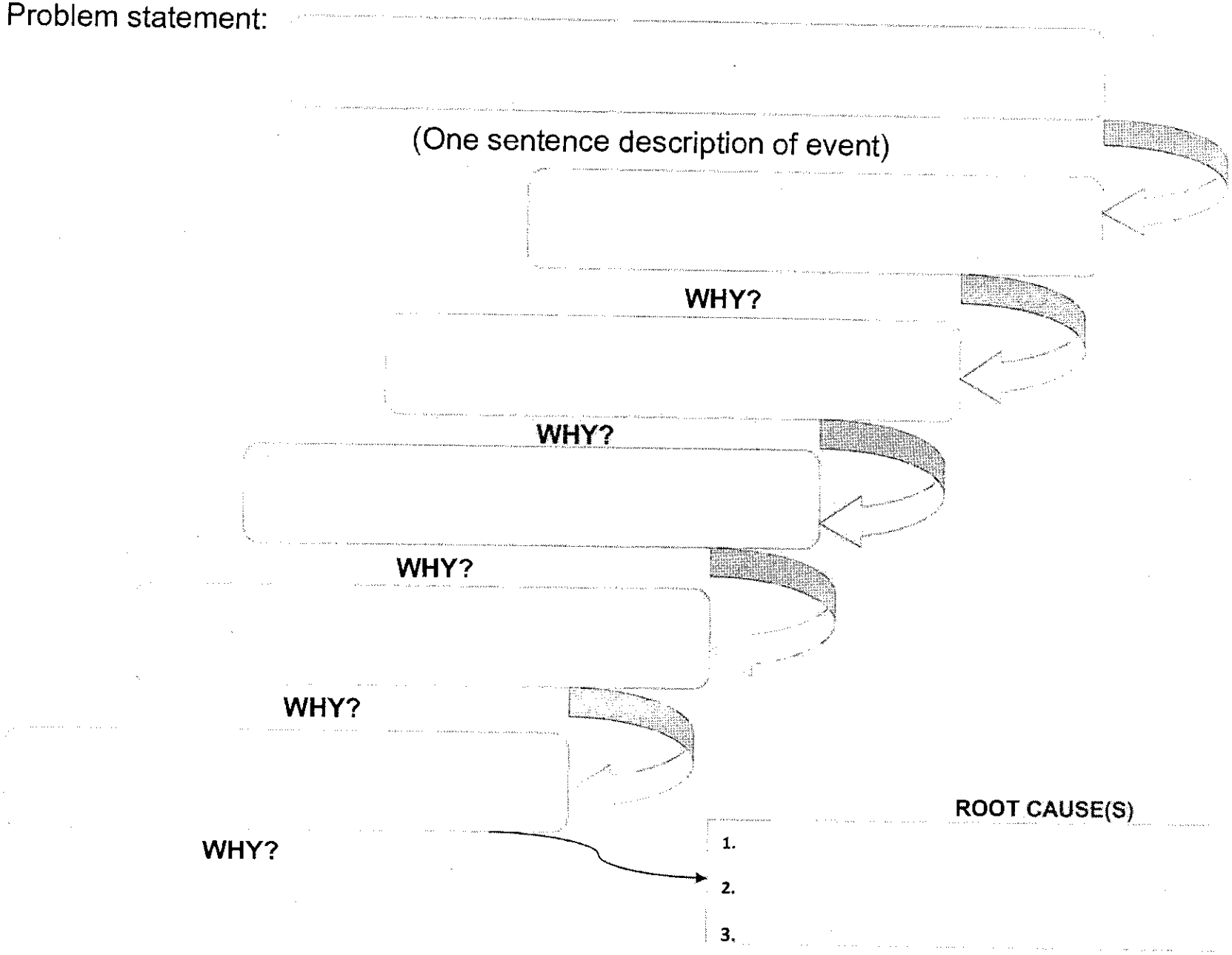
A Community training will be coordinated to educate all team members in the community regarding the Quality Assurance process at Spring Village at Essex. The first training will be conducted by the Director of Operations for WoodBine Senior Living and the Community's Director of Nursing. October 17, 2017. These trainings will occur at new hire orientation and annually thereafter. Quality Assurance education will be presented in several ways i.e. discussion, role play, use of examples etc. Every team member will be inserviced concerning community expectations relating to Quality Assurance participation i.e. concerns, suggestions, recommendations and ideas for best practice. The Executive Director will provide reassurances to all team members that no retaliation will occur as a result of sharing negative outcomes.

Quality Assurance (Continued)

The Executive Director at Spring Village at Essex, will insure residents and families (responsible parties), through Family and Resident Council Meetings, are made aware of the Community Quality Assurance process. They will be assured by the Executive Director that their opinions are valued and will be considered in the decision making for improvements and revisions to current Community practices.

In addition, the Quality Assurance process at Spring Village at Essex will be communicated through correspondence by the Executive Director to applicable vendors (i.e. mobile x-ray, mobile labs) and collaborating agencies i.e. (local Area Agency on Aging, Retired Senior Volunteer Program) in an effort to encourage their involvement in the Quality Assurance process. Correspondence will encourage their attendance at the Quality Assurance Meeting (as applicable), as well as their sharing of "Best Practices."

Problem statement:



To validate Root Causes-Ask the following:

If you removed this Root Cause, would this event have been prevented?